STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: Visiting Nurse and Hospice Care of Southwestern CT, Inc. of Stamford, CT d/b/a Visiting Nurse and Hospice Care of Southwestern CT, Inc.
1029 East Main Street
Stamford, CT 06902

CONSENT AGREEMENT

WHEREAS, Visiting Nurse and Hospice Care if Southwestern CT, Inc. (hereinafter the "Licensee"), has been issued License No.C821073 to operate a home health care agency known as Visiting Nurse and Hospice Care of Southwestern CT, Inc., (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on January 30, 2008 and concluding on April 9, 2008 and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated April 9, 2008 and revised on May 1, 2008 (Exhibit A – copy attached); and

WHEREAS, the Licensee is willing to enter into this Consent Agreement and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Anne W. Rich its Executive Director hereby stipulate and agree as follows:

1. Within twenty-one (21) days of the effect of the Consent Agreement all Facility nursing staff shall be in-serviced, to the policies and procedures related to issues identified in paragraph number 2 of this document.

2. Effective upon the execution of this Consent Agreement, the Licensee, through its Governing Body, Administrator/Supervisor of Clinical Services, Hospice Program Director and Supervisor of Clinical Services (Hospice) shall ensure substantial compliance with the following:
    a. The hospice shall maintain professional management of the care plan for all patients residing in a nursing home/other facility and coordinate all care with the nursing home/other facility where the patient resides;
    b. All plans of care shall be individualized and shall include assessment of the patient's/caregiver's/family's individual needs including drug therapies, treatments prescribed by the physician, assessment of patient/caregiver/family needs as they relate to hospice services, plans for interventions and implementation including the management of discomfort and symptom relief and goals of management;
    c. Hospice services shall be provided in accordance with each patient's comprehensive plan of care and integrated with the plan of care of the nursing home/other facility where the patient resides, if applicable;
    d. The Interdisciplinary Group shall conduct ongoing assessments of the needs of each patient/caregiver/family then, in collaboration, review and revise each patient care plan to reflect appropriate interventions, supervise all services provided by the hospice to ensure implementation, coordination and continuity of the plan of care in all settings and in accordance with applicable federal and state laws and regulations;
    e. All patients/primary caregivers shall be fully informed of the criteria for admission/discharge and the patient's current health status to ensure informed consent at the time of revocation of hospice services and/or discharge from services; and
    f. The hospice shall annually provide six (6) hours of in-service education to all direct service staff, including staff under contract with the nursing home or other facility where the patient may reside regarding the provision of to hospice patients.
3. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Agreement. The name of the designated individual shall be provided to the Department

within said timeframe. The assigned individual shall submit reports every six (6) weeks to the Department regarding the provisions contained within this document.

4. The Licensee shall include in the agency's Quality Assurance Program (QAP), in addition to the required quarterly clinical record reviews, a review of patient care issues including those identified in the May 1, 2008 violation letter.

5. The Licensee shall pay a monetary penalty to the Department in the amount of ~~five~~ two hundred fifty dollars ($250.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Agreement. The money penalty and any reports required by this document shall be directed to:

Victoria V. Carlson, RN, MBA
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

6. All parties agree that this Consent Agreement is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Agreement or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law. This Consent Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

7. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.

8. The terms of this Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.

9. The Licensee understands that this Consent Agreement and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is

executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.

10. Should the Licensee not be able to maintain substantial compliance with the requirements of the Consent Agreement the Department retains the right to issue charges including those identified in the May 1, 2008 violation letter referenced in this document.
11. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Agreement.

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WITNESS WHEREOF, the parties hereto have caused this Consent Agreement to be executed by their respective officers and officials, which Consent Agreement is to be effective as of the later of the two dates noted below.

VISITING NURSE AND HOSPICE CARE OF SOUTHWESTERN CT, INC. of STAMFORD, CT

7/14/08
Date

By: Anne W. Rich
Anne W. Rich, Executive Director

STATE OF CT)

County of Fairfield) ss Stamford 7/14 2008

Personally appeared the above named Anne W. Rich and made oath to the truth of the statements contained herein.

My Commission Expires: 11/30/2012
(If Notary Public)

Catherine Kelly Wilson

Notary Public	[✓]
Justice of the Peace	[ ]
Town Clerk	[ ]
Commissioner of the Superior Court	[ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

7/21/08
Date

By: Joan D. Leavitt
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 15

May 1, 2008

Anne Rich, RN, Administrator
Visiting Nurse & Hospice Care of Southwestern CT, Inc.
1029 East Main Street
Stamford, CT 06902

Dear Ms. Rich:

Enclosed please find revisions to the violation letter dated April 9, 2008.

Unannounced visits were made to Visiting Nurse & Hospice Care of Southwestern CT, Inc. on January 30, 31, 2008, February 1, 4, 5, 2008by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a Hospice Medicare survey with additional information received through April 9, 2008.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for April 23, 2008 at 1:00 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Victoria V. Carlson, RN

Victoria V. Carlson, RN, MBA
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SNC:NC:

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

c. Nurse Consultant

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(b) General requirements.

1. The governing body failed to assume responsibility for the services provided by agency staff to Patient #s 1, 2, 3, 4, 5, 6 and 8 to ensure the safety and quality of care rendered to all patients and their families and/or to provide sufficient staff to meet the needs of the patients at all times. The findings are based on the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(d)(2) General Requirements.

2. The administrator failed to organize and direct the agency's ongoing functions and to ensure the safety and quality of care rendered to Patient #s 1, 2, 3, 4, 5, 6 and 8 as evidenced by the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(2) Services.

3. Based on clinical record review, medication policy review and staff interviews it was determined that for two (2) of two (2) patients (Patient #s 1, 4) the nurse failed to document all pertinent information to identify specific medications that had been administered and/or pre-poured. The findings include:

a. Patient #1 had a start of care date of 8/23/07 with diagnoses of GI bleed, anemia, history of uterine cancer and UTI. The plan of care dated 8/23/07 included skilled nursing 2-3x a week to assess all systems, safety, demands and care needs, instruct in signs and symptoms (s/s) bleeding, medications, s/s to report, s/s of impending death and supervise the aide.
Review of the clinical record indicated that on 11/8/07 the hospice nurse began pre-pouring the patient's medications. Review of the nursing notes from 11/8/07 to 1/26/08 indicated that the nurse did not consistently document the weekly pre-pours and did not document the date of the medication list she used as the reference for the pre-pours. The nurse documented on the visit of 11/8/07 that she pre-poured the medications until 11/15/07 however the nurse did not document another pre-pour until the visit of 11/20/07. On the visit of 1/8/07 the nurse documented that she pre-poured the patient's medications until 1/15/08 however the nurse did not document that she pre-poured the patient's medications again until 1/23/07. The clinical record lacked documentation as to who pre-poured the patient's medications in the absence of the nurse.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

would administer the Prednisone taper therapy when ordered by the physician and administered the patient's PRN pain medications.
The nurse stated that she did not pre-pour the Prednisone or the patient's pain medication.

b. Patient #4's readmission start of care date was 6/1/07. The terminal diagnosis was breast cancer; related diagnoses included secondary bone and liver cancer. The plans of care dated 7/31/07 and 9/29/07 ordered skilled nurse 2-x week to assess vital signs, pain management, and medication compliance. Clinical record documentation from 7/31/07 to 11/6/07 indicated that RN #2 pre-poured medications for a week at a time, but failed to consistently document weekly pre-pours and/or the reference used for the pre-pours.
Review of agency policy identified that medications are documented when pre-poured with inclusions of the type and date of the reference tool used to pre-pour.
When interviewed on 2/5/08, RN #2 stated that she pre-poured the medications weekly and did not know a reference should have been cited in her documentation.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(3)(D) Services and/or D72(b)(2)(G) Patient care policies.

4. Based on clinical record review, agency policy review and physician and staff interviews, it was determined that for two (2) of eight (8) patients (Patient #s 1, 4) agency professional staff failed to assess and/or to document assessment of the individual's needs including the management of discomfort and symptom relief and/or appropriateness for hospice services. The findings include:

a. Patient #1 had a start of care date of 8/23/07 with diagnoses of GI bleed, anemia, history of uterine cancer and UTI. The plan of care dated 8/23/07 included skilled nursing 2-3x a week to assess all systems, safety demands and care needs, instruct in signs/symptoms (s/s) bleeding, medications, s/s to report, s/s of impending death and supervise the aide; home health aide 4-7x a week to assist with personal care. Physical therapy was referred on 8/24/07 for 2x a week to teach the caregiver transferring techniques and to assist the patient and caregiver.
The admission hospice assessment of 8/23/07 indicated that the patient lived alone but was to have a 24-hour private aide, was legally blind, bed bound, oriented but confused and forgetful, incontinent, had edema due to osteoarthritis and did not appear to be experiencing any pain.
Review of the clinical record from 8/23/07 to 2/4/08 indicated that the patient's health status had significantly improved since 9/15/07. The patient's appetite was noted as fair to good, was alert and oriented with functional status being bed to wheelchair with occasional ambulation with a walker. The patient had not experienced any GI bleeding since the hospitalization prior to hospice admission and noted that the patient continued to need assist with all ADLs and IADLs; the patient did not experience pain during most of the nursing visits. The clinical record lacked documentation to support the continued need for hospice care. RN #2 stated on 2/4/08 that she felt the patient would not live longer than 6-months since he/she was 98-years old and she felt he/she was appropriate for hospice services.

EXHIBIT A

DATE(S) OF VISIT: January 30, 31, 2008, February 1, 4, 5, 2008 with additional information received through April 9, 2008

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

i. The patient experienced occasional discomfort in the left hand from gout and lower back discomfort from arthritis. On the initial plan of care dated 8/23/07 the patient was on Morphine Sulfate (MoS04) q 4-6 hrs. prn for pain and on 11/13/07 the physician ordered Oxycodone 5/325 one tablet q 6 hrs. prn for pain. The nurse failed to consistently and/or accurately evaluate which pain medication the patient received and/or the effect of the pain medication. The clinical record lacked documentation to support that the nurse evaluated if the patient's medications were administered effectively until the nurse began pre-pouring the patient's medications on 11/8/07 although the record lacked documentation as to the reason for the pre-pour.

On the nursing visit of 12/7/07 the nurse documented that Oxycodone and Tylenol were taken for pain. On 1/23/08 the nurse noted that Tylenol arthritis formula was used to relieve pain but the medication was not listed on the patient's medication list and the note did not indicate the frequency and effect of the medication. A case conference note of 1/17/08 between the Supervisor of Clinical Services (SCS) and the PT indicated that a Lidocaine patch might have benefited the patient. The record lacked documentation to support that the nurse conferred with the physician regarding the recommendation and/or that it was implemented.

RN #2 stated on 2/4/08 that the nurse started pre-pouring the patient's medications due to the friend's other commitments and the patient was more alert and oriented about the medications. The aide did not keep a log as to the frequency of administering the pain medications.

During a home visit to the patient on 1/30/08 the private aide told the surveyor that she usually gave the patient Tylenol for the pain, which was effective and she did not use the Oxcycodone. During the home visit, the patient denied pain.

The nurse failed to consistently and/or accurately re-evaluate the patient's continued need for hospice care and/or failed to accurately assess the patient's pain and to provide pain management.

b. Patient #4's readmission start of care date was 6/1/07. The terminal diagnosis was breast cancer; related diagnoses included secondary bone and liver cancer. The plans of care dated 7/31/07 and 9/29/07 ordered skilled nurse 2 x wk to assess vital signs, pain management and medication compliance; MSW 2-3x monthly to prepare family/friends for patient's death, H-HHA 5x wkly for personal care. Ordered medications included, Oxycodone-Acetominophen PRN, and OxyContin extended release 60 mg twice daily. On the sixty-day summary to the physician dated 7/30/07 RN #2 identified that Patient #4 was declining, had increased pain, shortness of breath and weakness and required much support that included increased home health aide service. On 8/27/07 RN #2 identified that the patient had constant pain at the chest and hips that was 7/10 at best and 9/10 at worst. RN #2 contacted the physician and Oxycontin was increased from 60 mg twice daily to 80 mg twice daily. RN #2 consistently documented from 8/31/07 to 9/21/07 that chest wall and hip pain was improved, but continued constant, ranging from 4/10 to 8/10. On 9/25/07 RN #2 documented on a verbal order to the physician that the patient complained of confusion and requested to decrease the Oxycontin dose back to 60 mg twice daily. RN #2 consistently identified that from 9/25/07 thru 11/2/07 that chest wall and hip pain were constant, ranging from 4/10 to 8/10.

Throughout the period from 6/1/07 to 11/2/07 RN #2 failed to identify and/or failed to document how much medication the patient was using, the onset, duration and/or quality of relief obtained.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

When interviewed on 2/5/08, RN #2 stated that she did not assess the amount of medications the patient was taking and/or the onset or duration of relief. RN #2 stated that she measured how the pain regime worked by assessment of pain level (during visits) and by asking if the patient was OK to which the patient usually responded that he/she was fine.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (a)(3)(A)(iv)(E) Patient care policies.

5. Based on clinical record review, staff interviews and agency policy it was determined that for Patient #4, whose services were terminated when tgoals of care had not been met and the patient continued to require home health care services, the agency failed to conduct appropriate discharge planning. The findings include:

a. Patient #4's readmission start of care date was 6/1/07. The terminal diagnosis was breast cancer; related diagnoses included secondary bone and liver cancer. The plans of care dated 7/31/07 and 9/29/07 ordered skilled nurse 2x week to assess vital signs, pain management, medication compliance; MSW 2-3x monthly to prepare family/friends for patient's death; H-HHA 5x wkly for personal care. Documentation by RN #2 dated 11/2/07 indicated that special services (routine home care) would be provided when the patient was discharged from hospice. Documentation by MSW #1 dated 11/6/07 identified ongoing need for social services that would continue to be provided 2-3 times per month to encourage ventilation of feelings and concerns and during the period from 10/1/07 to 11/6/07 the home health aide consistently documented visits 5 times a week to assist with personal hygiene and most ADLs/IADLs. RN #2 documented on 11/6/07 that special services would be provided when insurance authorization was obtained; the patient was discharged from hospice services however, there was no documentation of a discharge plan to assure that the patient's health care needs and/or hygiene needs would be met.
On 11/8/07 the Hospice Administrator identified that the insurance policy was terminated, but that another policy was located. On 9/13/07 RN #2 documented that the agency continued to await insurance authorization. During the period from 11/7/07 to 11/15/07 there was no documentation that home health services were provided.
Review of agency policy for discharge before goals are met, identified that a case review is conducted prior to termination of services and includes all parties involved in the patient's care. When the case review decision is to discharge from service, the administrator shall notify the patient and/or family and the physician that services shall be discontinued in ten days.
When interviewed on 2/5/08 RN #2 stated that she called the patient on 11/9/07 and 11/13/07 and the patient told her everything was OK.
When interviewed on 2/7/08 the primary physician stated that no person from the hospice had informed him that home health services would not be provided while the patient was being treated with RT and in his opinion, hospice services should not have been revoked.
When interviewed on 2/5/08 the Hospice Administrator stated that she was looking for a record of

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

services provided from 11/7/07 to 11/15/07. On 2/13/08 the Hospice Administrator stated that no services were provided to the patient during the period from 11/7/07 to 11/15/07.
The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (b)(2)(B)(vi) Patient care policies.

6. Based on review of in-service programs provided to nursing homes where the hospice had contracts to provide hospice inpatient and routine level of care to residents, it was determined that during the period from 2/5/06 to 2/5/08 the agency failed to provide hospice orientation and/or training to educate all providers of care to the hospice philosophy of patient care and/or to educate unlicensed personnel assigned to provide services to hospice patient/families regarding hospice goals, philosophy and approaches to care. The findings include:

a. Documentation given to the surveyor on 2/5/08 by the Hospice Director identified that during the period from 2/5/06 to 2/5/08 the hospice provided care to patients in two nursing homes for which they had not provided orientation and/or in-service training and in a third nursing home the orientation/training was provided to the second and third shifts of the nursing home by a nursing home employee with no hospice experience.
When interviewed on 2/5/08 the Hospice Director stated that it has been difficult to find the time and/or personnel to conduct in-service programs at the nursing homes and to educate nursing home personnel when patients are cared for in the nursing home.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (b)(2)(G) Patient care policies.

7. Based on clinical record reviews and staff interview it was determined that for two (2) of eight (8) patients (Patient #s 3, 4) the agency failed to provide care in accordance with the physician's written plan of care. The findings include:

a. Patient #3's start of care date was 11/20/07. The terminal diagnosis was colon cancer with secondary cancers of the liver, lung and kidney.
The physician's plan of care dated 11/20/07 ordered skilled nurse 1-3 x per week to assess change in condition, vital signs, pain and family's understanding of pain and symptom management; MSW evaluation and H-HHA 5-7 x per week. The MSW care plan dated 11/27/07 ordered visits 2-3 times monthly to reassure patient/family of social/emotional factors, encourage ventilation of feelings/fears, prepare family/friends for patient's death and to provide psychosocial education regarding the dying process. On 11/21/07 the pastoral minister identified that the patient had three supportive and close children including a daughter who visited daily and carried most of the responsibility. An older child was detached from the family due to stressful relationships. On 11/27/07 MSW #1 identified that she met with the patient's daughter who was aware of the patient's poor prognosis. During the period from 11/27/08 to 12/8/08 MSW #1 visited the patient bi-weekly and identified interaction with the patient,

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

but there was no documentation to indicate that MSW #1 met and/or spoke with family members. On 1/23/08 MSW #1 identified that the patient was stable, had no psychosocial issues, and the patient was discharged from social services. There was no documentation that MSW #1 contacted the patient's family members to assess and/or intervene to address their feelings/fears about the patient's impending death and/or to provide psychosocial education regarding the patient's death as ordered in the physician's plan of care.
When interviewed on 1/31/08 MSW #1 stated that the daughter was not present when social service visits were made and there was no contact with the patient's family prior to discharging the patient.

b. Patient #4's readmission start of care date was 6/1/07. The terminal diagnosis was breast cancer; related diagnoses included secondary bone and liver cancer. The plans of care dated 7/31/07 and 9/29/07 ordered skilled nurse 2 x wk to assess vital signs, pain management and medication compliance, MSW 2-3x monthly to prepare family/friends for patient's death, reassurance of patient/family through death, prepare family/friends for patient's death, provide psychosocial education regarding dying process, encourage ventilation of feelings/fears; H-HHA 5x weekly for personal care. In the 9/6/07 IDT meeting notes, MSW #1 identified that the patient was anxious and that a son-in-law's mother had died. On 9/11/07 MSW #1 identified that the patient told her that the son-in-law's mother had died in hospice. During the next revisit on 10/4/07 MSW #1 identified that the patient reported that the recent death of the son-in-law's mother was upsetting and restated the plan to revisit 2-3 times per month to encourage ventilation of feelings and concerns. On 11/6/07 MSW #1 revisited and identified that the patient decided to have radiation therapy (RT) for severe hip pain. There was no documentation to indicate that MSW #1 addressed the psychosocial needs identified during the period from 9/6/07 to 10/4/07 and/or that social services were provided 2-3 times per month as ordered. On the discharge summary to the physician dated 11/6/07 MSW #1 identified that social services were provided to offer reassurance, but failed to include a summary of the patient's psychosocial status.
When interviewed on 2/5/08, MSW #1 stated that the patient's environment was chaotic with a spouse who came and went, multiple household members and numerous financial constraints. The plan was to talk to and listen to the patient, but visits were only monthly because insurance authorizations were a problem.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (b)(2)(G)(i)(ii) Patient care policies.

8. Based on clinical record reviews, agency policy review and staff interviews it was determined that for seven (7) of eight (8) patients (Patient #s 1, 2, 3, 4, 5, 8), the Interdisciplinary Team (IDT) failed to appropriately supervise the care and services for each hospice patient . The findings include:

a. Review of all IDT minutes for Patient #s 1, 2, 3, 4, 5, 8 from 3/22/07 to 1/24/08 identified that the IDT failed to appropriately supervise the care and services of the hospice patients and/or the hospice

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

nurse failed to inform the IDT of critical changes in the patient's status and the need to alter the plan of care. The IDT meeting minutes failed to identify that the IDT had discussed and/or made recommendations for each patient, including hospice covered medications.

b. Patient #1 had a start of care date of 8/23/07 with diagnoses of GI bleed, anemia, arthritis, history of uterine cancer and UTI. The plan of care dated 8/23/07 included skilled nursing 2-3x a week to assess all systems, safety demands and care needs, instruct in s/s bleeding, medications, s/s to report, s/s of impending death and supervise the aide. The nurse referred for home health aide 4-7x a week to assist with personal care. Physical therapy was referred on 8/24/07 2x a week to teach the caregiver transferring techniques and to assist the patient and caregiver.
Review of the clinical record from 8/23/07 to 1/26/08 indicated that the patient's health status and mental status had improved since 9/07. The patient was alert and oriented, ambulated a very short distance with a walker, received PT services since 9/4/07, appetite had improved and the patient had an occasional exacerbation of gout and/or arthritic pain which was resolved with Prednisone taper, however most of the time the patient was pain free. The patient did not have any further GI bleeding. The nurse pre-poured the patient's medications since 11/8/07. The patient did not receive MSW services. The patient had not received hospice aides since 11/6/07.
The patient was recertified for hospice on 11/22/07.
The IDT meeting minutes from 8/23/07 to 1/10/07 documented only the services and the frequency of services the patient was receiving. The IDT minutes failed to discuss the patient's improved health status and/or did not identify any discussion/communication regarding the appropriateness of the patient's hospice recertification on 11/22/08.

c. Patient #2 had a start of care of 08/24/08 with a primary diagnosis of end-stage Alzheimer's and a secondary diagnosis of generalized arthritis.
Review of the initial IDT minutes dated 08/30/07 documented the patient received personal care from an ALSA aide and resided in an assisted living facility. There was no clinical record documentation that the IDT inquired if the patient's family had been informed that the aide (H-HHA) service was part of the hospice Medicare benefit. There was no documentation in any IDT minutes that the hospice nurse was not pre-pouring the medications and that medications were being pre-poured by the ALSA. The patient's family paid the ALSA privately for the ALSA RN to pre-pour medications and the H-HHA service.
When interviewed on 02/01/08, RN #1 stated the IDT never questioned why the patient received aide service from the ALSA and not from the hospice.
When interviewed on 02/01/08, the Hospice Director stated the agency should offer all hospice services, including medication pre-pour by a RN and H-HHA service to patients; she was unfamiliar with the case therefore did not know if, or what, the IDT discussed concerning the aide and who was pre-pouring the medications.
The IDT and/or RN #1 failed to discuss why the hospice was not providing the medication pre-pour from 08/24/07 thru 01/14/08 (when the patient moved to the hospice residence) and/or why the hospice did not provide H-HHA from 08/24/07 thru 09/09/07.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

d. Patient #3's start of care date was 11/20/07. The terminal diagnosis was colon cancer with secondary cancers of the liver, lung and kidney. The physician's plan of care dated 11/20/07 ordered skilled nurse 1-3 x per week to assess change in condition, vital signs, pain and family's understanding of pain and symptom management; MSW evaluation and H-HHA 5-7 x per week. Ordered medications included Megace daily. On 11/20/07 RN #4 identified that this 73-year old patient lived in a nursing home, was alert and oriented to person with impaired memory, had slight dysphagia, but appetite was fair with consumption of at least ½ of meals. The patient was dependent for most ADLs and refused to get out of bed most days. Three adult children were attentive and a daughter visited daily.
On 12/11/07, MSW #1 identified that appetite was poor and RN #4 identified decreased appetite on 12/12/07. On 12/19/07 the hospice pastor identified that the patient's lower dentures were missing, but there was no documentation that this was communicated to the primary care nurse and/or the IDT. On 12/26/07 RN #4 revisited and identified that the teeth were missing, but there was no documentation of a plan to intervene and/or communication with the IDT.
During the period from 12/27/07 to 1/25/08 RN #2 visited weekly, but failed to consistently assess appetite; MSW #1 consistently documented poor appetite during bi-weekly visits through 12/31/07 and on 1/14/08 and 1/29/08 the pastoral minister identified that the patient continued to be without lower dentures. During the period from 12/13/07 to 1/24/08 the IDT met biweekly, but there was no clinical record and/or meeting minute documentation to indicate that poor appetite and/or missing dentures were discussed.
When interviewed on 2/1/08 RN #4 stated that she telephoned the Hospice Director about the missing teeth, but could not recall the date and had not documented the call. When interviewed on 2/1/08 the Hospice Director stated that RN #4 told her about the missing teeth on 1/3/08 and at that time the Director, in collaboration with the nursing home, arranged for the patient to see a dentist, but had not documented these events. During a joint visit to the nursing home on 1/30/08 the surveyor observed that the patient still had no lower teeth. RN #4 told the surveyor that the patient's dentist refused to provide services because appropriate paper work did not accompany the patient to the dentist's office. There was no documentation that this issue was discussed with the IDT. On 2/5/08 the Hospice Director told the surveyor that the patient's daughter found that getting the patient to the dentist again was too difficult and planned to not pursue the issue any further.
Review of the nursing home Medication Administration Record (MAR) identified that Megace was ordered, but RN #4 stated that this medication was ordered previous to the hospice admission and RN #4 determined that the medication should not be covered by the hospice because the patient appeared to be well nourished. During the period from 11/20/07 to 1/30/07 there was no documentation in hospice IDT meeting minutes to indicate that the IDT discussed which medications were related to the terminal diagnosis and/or should be provided by the hospice.

e. Patient #4's readmission start of care date was 6/1/07. The terminal diagnosis was breast cancer; related diagnoses included secondary bone and liver cancer. The plans of care dated 7/31/07 and 9/29/07 ordered skilled nurse 2x wk to assess vital signs, pain management, medication compliance and the nurse pre-poured medications weekly; MSW 2-3x monthly to prepare family/friends for patient's

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death, H-HHA 5x wkly for personal care. Clinical record documentation by RN #2 and MSW #1 during the period from 7/31/07 to 11/6/07 identified that Patient #4 was alert and oriented, had recurrent peri-orbital edema, sinus infections, neck pain and stiffness, dyspnea with exertion, constant (severe) pain of the chest wall and hips, was weak and frail and required home health aide assistance with most ADLs. The patient lived with a spouse, daughter, son-in-law and three young children including an infant, but was alone during most days. Documentation by agency home health aides during the period from 7/13/07 to 11/6/07 indicated that in addition to personal care hygiene and homemaking, the aide assisted the patient to the bathroom, prepared lunch and fluids, reminded to take medications and assisted to ambulate.

Documentation by RN #2 dated 11/2/07 identified that the physician was planning RT for hip pain palliation.

RN #2 identified that the patient understood the concept of hospice and would be transferred to special services (routine home care) while receiving RT. On 11/6/07 RN #2 identified that hospice benefits were revoked and the patient would be admitted to special services when the insurance granted approval. Medications were pre-poured through 11/13/07. There was no documentation of a discharge plan that determined how the patient's ongoing health care, personal hygiene and/or medication pre-pour needs would be met. IDT meeting notes for the period between 10/1/07 and 11/6/07 could not be found and there was no clinical record documentation to support that the issues surrounding revocation and/or discharge were discussed by the IDT and/or with the attending physician.

Review of agency policy determined that the patient/family/caregiver and attending physician participates in the development of the care plan and ongoing changes. A comprehensive review of the care plan is done at the time of significant changes and written evidence of care coordination is found in the written interdisciplinary plan of care and coordination notes in the patient's clinical record.

When interviewed on 2/5/08 the Hospice SCS stated that Patient #4's plan to have RT was discussed at IDT as a palliative treatment, but the hospice medical director thought that alternative treatments should be tried first. The SCS stated that the attending physician was not consulted about this and the IDT relied on the nurse's input only. The Hospice SCS stated that the IDT discussion was not documented.

When interviewed on 2/5/08 the agency administrator stated that records of IDT meetings could not be found for this patient during the period from 10/1/07 to 2/5/08.

Documentation by the primary physician dated 11/8/07 (received by the surveyor from the agency on 2/14/08) stated that the patient had been bothered by left hip pain for several months and that previous CAT scans had shown extensive skeletal involvement, including the left hip. The pain could be adequately controlled with narcotic medications, but the patient had significant sedation with these medications. The patient wanted to try radiation therapy and the physician agreed.

When interviewed on 2/7/08 the primary physician stated that the high narcotic dose required to relieve the patient's severe pain caused unacceptable side effects and RT was the optimal palliative treatment. The primary physician stated that the patient should not have been taken off of the hospice benefit because the treatment was palliative and necessary and that no hospice professional consulted with him about the availability of alternative treatments and/or the patient's loss of benefits.

f. Patient #5 had a start of care date of 10/23/07 with diagnoses including COPD, cancer of the rectum,

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diabetes and hypertension. The plan of care dated 10/23/07 included skilled nursing 2-3x a week, home health aide 7x a week and refer for a PT evaluation. The assessment dated 10/23/07 indicated that the patient had end stage COPD, shortness of breath (SOB) at rest, had lost 10 lbs., exhibited a decreased appetite, transferred from bed to chair and needed assist with all ADLs and IADLs. The patient was weak, anxious, fatigued and forgetful at times. The clinical record noted that the patient's son and daughter were in and out of the patient's home frequently.
The nursing note of 10/26/07 noted that the patient complained of increased anxiety since he/she did not like being alone and took Xanax q 6 hr. for the anxiety. The subsequent nursing note of 10/30/07 stated that the patient had a depressed mood and a flat affect. The nurse noted that the patient had stopped taking Zoloft and the nurse encouraged him/her to resume the medication. A case conference note of 10/26/07 stated that the patient was tearful and realized that no further treatment would be beneficial for him/her. The clinical record noted that MSW services were refused
Review of the IDT meeting minutes of 10/25/07 and 11/1/07 lacked documentation of a discussion regarding the patient's anxiety/depression/hopelessness and only documented the services and frequency of services provided to the patient. The minutes of the 10/25/07 IDT noted that MSW, pastoral, bereavement and volunteer services were not needed however, documentation was lacking of discussion/recommendations by the IDT to address the patient's depression. The patient went to the ER and expired on 11/2/07.
RN #2 stated on 2/4/08 that the patient was depressed due to not taking Zoloft and she encouraged the patient to continue taking the medication.

g. Patient #8 had a start of care date of 9/18/07 with diagnoses of cancer of the colon with metastasis to the liver. The plan of care dated 9/18/07 included skilled nursing 1-3x a week, physical therapy 2-4x a month, MSW 2-3x a month. The admission assessment indicated that the patient was diagnosed with colon cancer in 2005 and was hospitalized on 9/14/07 and a CAT scan revealed a mass in the colon with metastasis to the liver. The patient reported that he/she felt much better each day with an increase in appetite. The patient ambulated with the assist of one and a walker outdoors. The patient was independent in ADLs.
The MSW initial assessment of the patient was on 9/21/07. The MSW visits of 9/26/07 through 10/25/07 indicated that the MSW reviewed/initiated applications with the patient/caregiver for community agencies and respite agencies that would provide companion/homemaker services for the patient to assist with meal preparation since the patient identified that this was an issue. The patient had lost considerable weight and requested assistance with meal preparation at least 3x a week.
Review of the IDT meetings minutes of 10/4/07 and 11/1/07 indicated that the MSW was assisting the patient/caregiver with obtaining the respite grant. The clinical record and/or the IDT meeting minutes failed to have documentation to support any discussion regarding the need for the hospice agency to provide homemaking services to the patient for meal preparation while awaiting approval of the respite grant. The patient did not receive this service from admission until the patient revoked the benefit on 11/2/07.
The patient began receiving Xeloda on 10/4/07 to shrink the liver tumor. Review of IDT meeting minutes from 9/20/07 to 11/1/07 indicated that the patient did not exhibit any side effects from the

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Xeloda, which was started on 10/4/07. The nursing note of 10/31/07 noted that the patient and caregiver were informed that the patient would need to revoke the hospice benefit and be transferred to regular home care due to starting the new medication Xeloda. The IDT meeting minutes of 11/1/07 failed to mention/discuss the revocation of the hospice benefit by the patient as per the agency's protocol. The Supervisor of Clinical Services stated on 2/1/08 that the IDT discusses patient issues at length but the documentation does not support the areas discussed at the meetings.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (b)(2)(G)(ii) Patient care policies.

9. The hospice supervisor of clinical services failed to coordinate and manage all services to hospice patients and families to ensure the safety and quality of care rendered to Patient #s 1, 2, 3, 4, 5, 6 and 8 as evidenced by the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (b)(2)(J) Patient care policies.

10. The hospice program director failed organize and direct the hospice agency's ongoing functions and to ensure the safety and quality of care rendered to Patient #s 1, 2, 3, 4, 5, 6 and 8 as evidenced by the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D73(b) Patient care plan.

11. Based on clinical record review and staff interview it was determined that for six (6) of seven (7) patients (Patient #s 1, 3, 4, 5, 6, 8) the agency failed to assure that the initial plan of care and/or any modifications were signed by the physician within 21 days. The findings include:

a. Patient #1 had a start of care date and a physician's plan of care dated 8/23/07 to 10/22/07. The plan of care of 8/23/07 was not signed by the physician until 10/23/07. The recertification plan of care dated 10/22/07 to 12/21/07 was not signed by the physician until 12/4/07.

b. Patient #3's start of care date was 11/20/07. The initial physician's plan of care dated 11/20/07 to 1/18/08 was not received by the agency, signed by the physician until 1/9/08.

c. Patient #4's readmission start of care date was 6/1/07. The physician did not sign the resumption plan of care dated 6/1/07 to 7/30/07 until 9/10/07. The physician did not sign the recertification plans of care dated 7/31/07 to 9/28/07 and 9/29/07 to 11/27/07 until 9/10/07 and 11/05/07 respectively.

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The physician did not sign a verbal order dated 8/27/07 until 10/17/07. A physician's verbal order dated 9/25/07 was unsigned on 2/5/08.
When interviewed on 2/5/08 the Hospice SCS stated that late orders were common with some physicians and that the agency did not have a plan for tracking the orders. On 2/5/08 the home health director stated that the agency had a tracking system for late orders, but could not explain how the orders in question were not followed through on and/or addressed.

d. Patient #5 had a start of care date of 10/23/07 and a physician's plan of care dated 10/23/07 to 12/21/07. The plan of care of 10/23/07 was not signed by the physician until 12/6/07.

e. Patient #6 had a start of care date of 3/19/07 and a physician's plan of care dated 3/19/07 to 5/7/07. The plan of care of 3/19/07 was not signed by the physician until 5/7/07.

f. Patient #8 had a start of care date of 9/18/07. The physician's plan of care dated 9/18/07 to 11/16/07 was not signed by the physician until 11/14/07.

g. The Hospice Director stated on 2/5/08 that the hospice did not have a tracking system for timeliness of physician's orders. The agency failed to have the initial physician's plan of care and any modifications signed by the physician within 21 days.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D78(a) Patient's bill of rights and responsibilities.

12. Based on clinical record review, staff interviews and agency policy review it was determined that for four (4) of eight (8) patients (Patient #s 1, 2, 3, 8) the agency failed to provide pharmaceuticals as needed for the palliation and management of the terminal illness and related conditions and/or documentation was lacking of the role for the IDT in determining medications to be provided under the Medicare Hospice Benefit and/or the agency failed to inform the patient/family, both orally and in writing, of the billing mechanism for medications while receiving hospice services . The findings include:

a. Patient #1 had a start of care date of 8/23/07. The patient's plan of care dated 8/23/07 included the following medications: Metoprolol, Diovan, Norvasc, Lexapro and MoSO4 On 11/13/07 the physician ordered Oxycodone for pain and on 11/20/07 Senecot and Estraderm patch.
The hospice director stated on 1/31/08 that hospice contracted with one pharmacy for medications. The hospice paid a per diem rate to the pharmacy for all hospice patients in order to assure 24-hour coverage for all patients. A patient may elect to go to another pharmacy for their medications and would have to pay independently for their medications.
Patient # 1's friend elected to purchase the patient's prescriptions from a pharmacy for which the hospice agency did not have a contract, therefore the patient paid for all his/her medications.

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The agency administrator stated on 3/27/08 that the hospice nurse explains to the patient/family that medication reimbursement is provided through the agency's contracted pharmacy. The agency lacked

documentation to validate that patients are provided orally and in writing of the billing mechanism for the reimbursement of medications.

b. Patient #2 had a start of care of 08/24/07 with a primary diagnosis of end-stage Alzheimer's and a secondary diagnosis of generalized arthritis. The patient's medications were Lorazepam, ABHR Gel, Hyoscyamine Sulfate, Glucosamine Chondrotin, Calcium, ASA, Colace and Tylenol Arthritis.
Review of the clinical record and direct observation of the patient during a home visit made on 01/31/08, identified the patient was able to swallow medications, had a very good appetite, would grimace if arthritic pain interfered with turning and could no longer ambulate.
When interviewed on 02/01/08, RN #1 stated the hospice paid only for the medications contained in the "comfort pack", i.e. Lorazapam, ABHR Gel and Hyoscyamine Sulfate; the family purchased the other medications. Review of the agency pharmacy bill dated December 2007, identified $0.00 payment had been made for this patient's medications.
When interviewed on 02/01/08, the Hospice Director stated the $0.00 payment was an error on the pharmacy's part; the agency ordered and paid for the "comfort pack" medications. The Hospice Director stated, "it is apparent there are inconsistencies as to how the agency is paying for diagnosis related medications; at a minimum, the hospice should have paid for the Tylenol Arthritis and Colace".
The hospice failed to provide pharmaceuticals needed for the management of the terminal illness and related condition.

c. Patient #3's start of care date was 11/20/07. The terminal diagnosis was colon cancer with secondary cancers of the liver, lung and kidney. Ordered medications included Megace daily and review of the nursing home MAR for November and December 2007 indicated that Megace was administered daily. During the period from 11/20/07 to 1/25/08 RN #4 and MSW #1 consistently documented that appetite was decreased and/or poor. During a joint visit to the patient on 1/31/08 RN #4 told the surveyor that Megace was not provided by the hospice.
When interviewed on 1/31/08 the Hospice Director stated that Megace was not covered because it was determined to be not related to the terminal diagnosis.
Review of the nursing home Medication Administration Record (MAR) identified that Megace was ordered, but RN #4 stated that this medication was ordered previous to the hospice admission and RN #4 determined that the medication should not be covered by the hospice because the patient appeared to be well nourished. During the period from 11/20/07 to 1/30/07 there was no documentation in hospice IDT meeting minutes to indicate that the IDT discussed which medications were related to the terminal diagnosis and/or should be provided by the hospice.

d. Patient #8 had a start of care date of 9/18/07 with diagnosis of cancer of the colon with metastasis to the liver. The plan of care dated 9/18/07 included skilled nursing 1-3x a week, physical therapy 2-4x a month, MSW 2-3x a month. The patient was started on Xeloda on 10/4/07 to shrink the tumor in the

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liver and evaluate the results. The patient was asked to revoke his/her hospice benefit on 10/31/07 since the physician was going to continue with Xeloda to prolong his/her life.
The director of hospice stated on 2/12/08 that the patient's physician billed the patient's insurance carrier for the Xeloda from 9/18/07 to 11/2/07 instead of billing to the hospice benefit.